

# Consultation Admittance Form

Last Name:		First Name:	Gender: M / F / Other	
Address:		City, Province:	Postal Code:	
Phone (Home) (     )		Phone (Work) (     )	Phone (Cell) (     )	
Alberta Health Care #			Third Party Insurance #	
Emergency Contact Name:			Emergency Contact Phone (     )	
Date of Birth:	Age:	Height:	Weight:	
Occupation:			Marital Status:    Single    Married    Widowed    Divorced	
Email address: (optional)			(Email will be used for appointment reminders and office updates.)	

How did you hear about us? \_\_\_\_\_

**Please check all answers and fill in the blanks where appropriate.**

Reason(s) for appointment: \_\_\_\_\_

When did your condition begin? \_\_\_\_\_

Have you ever had similar problems?     Yes     No

Have you had X-rays, MRI, or other tests for this condition?     Yes     No    Which tests, when? \_\_\_\_\_

Is this a work related injury?     Yes     No    Has your employer been notified?     Yes     No

Is this a Motor Vehicle Accident (MVA)?     Yes     No    On what date did the accident occur? \_\_\_\_\_

Can you perform daily home activities?     Yes     Yes, but only with help     Not at all

Can you perform your daily work activities?     All activities     Only some activities     Not at all

Describe your stress level     None     Mild     Moderate     High

Do you exercise?     Daily     Occasionally     Not at all

What kinds of exercise do you do? \_\_\_\_\_

List all previous surgeries, illnesses, injuries (including MVA): \_\_\_\_\_

Have you had previous chiropractic care?     Yes     No    Dr. \_\_\_\_\_    Date: \_\_\_\_\_

Family doctor name: Dr. \_\_\_\_\_

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: \_\_\_\_\_

Date: \_\_\_\_\_    Patient signature: \_\_\_\_\_

# Health History Questionnaire

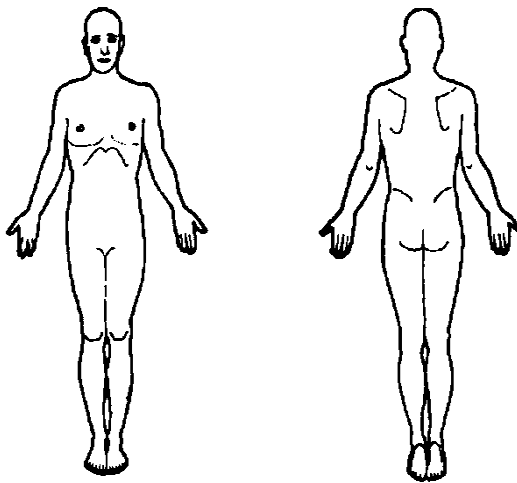
Patient name \_\_\_\_\_

Date \_\_\_\_\_

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure ----- Yes No
2. Hardening of the arteries (arteriosclerosis)----- Yes No
3. Diabetes----- Yes No
4. Tuberculosis----- Yes No
5. Cancer----- Yes No  
Where? \_\_\_\_\_
6. Heart or blood diseases----- Yes No
7. Bone spurs on the neck bones (cervical sprain)----- Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain)----- Yes No
9. Have you or any of your relatives ever suffered a stroke? ----- Yes No
10. Were you ever a smoker? ----- Yes No  
From \_\_\_\_\_ to \_\_\_\_\_
11. Do you take medication on a regular basis? ----- Yes No
12. Visual disturbances (blurring, loss, double vision)----- Yes No
13. Hearing disturbances (loss, ringing, other noise) ----- Yes No
14. Slurred speech or other speech problems ----- Yes No
15. Difficulty swallowing ----- Yes No
16. Dizziness ----- Yes No
17. Loss of consciousness, even momentary blackouts ----- Yes No
18. Numbness, loss of sensation, loss of strength or weakness in the face,  
fingers, hands, arms, legs, or any other parts of the body? ----- Yes No
19. Sudden collapse without loss of consciousness----- Yes No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |  
No pain Extreme pain

# Systems Review

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Circle any conditions that are **presently** causing you a problem.

Underline those that have caused you problems in the **past**.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever Sweats Fainting Sleep disturbance Fatigue Nervousness Weight loss Weight gain	Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Asthma	Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Prostate trouble Uncontrollable urine flow
NEUROLOGICAL	CARDIOVASCULAR	GASTROINTESTINAL
Visual disturbance Dizziness Fainting Convulsions Headache Numbness Neuralgia (nerve pain) Poor coordination Weakness	Rapid beating heart Slow beating heart High blood pressure Low blood pressure Pain over heart Hardening of arteries Swollen ankles Poor circulation Palpitations Cold hand or feet Varicose veins	Poor appetite Difficult digestion Heartburn Ulcers Nausea Vomiting Constipation Diarrhea Blood in stool Gallbladder/jaundice Colitis
EYES, EARS, NOSE, THROAT	MUSCLE & JOINT	FOR WOMEN ONLY
Eye pain Double vision Ringing in ears Deafness Nosebleeds Trouble swallowing Hoarseness Sinus infection Nasal drainage Enlarged glands	Neck pain Low back pain Arm pain Shoulder pain Leg pain Knee pain Foot pain Pain/numbness down arms or legs Pain between shoulders swollen joints Spinal curvature Arthritis Fractures	Painful menstruation Hot flashes Irregular cycle Cramps or back pain Vaginal discharge Nipple discharge Lumps in breast Menopausal symptoms Birth control pills Miscarriages Complications with pregnancy Pregnant? Y / N Week? Other:

# CHIROPRACTIC CASE HISTORY

PATIENT NAME

GENDER M / F

CHART #

ABH #

INSURANCE #

DATE

HOME ADDRESS

PHONE (H) ( )

PHONE (W) ( )

PHONE (C) ( )

MARITAL STATUS S M W D

DATE OF BIRTH

AGE

**1 CHIEF COMPLAINT**  
(include symptoms)

**2 HISTORY of CONDITION**  
(mode of onset, course, prior treatment, prior occurrence)

**3 FREQUENCY**

**4 INTENSITY**

**VAS Pain Intensity Scale**  
1 2 3 4 5 6 7 8 9 10  
Least Worst

**5 CHARACTER**

**6 DURATION**

**7 AGGRAVATING FACTORS**

**8 RELIEVING FACTORS**

**9 ASSOCIATED SYMPTOMS**  
(pain radiations, nausea, etc.)

**10 SYSTEMS REVIEW**

**11 MEDICAL HISTORY**  
(past illness, surgeries, past injuries, etc.)

**12 RELATED FAMILY HISTORY**

**13 PSYCHO-SOCIAL HISTORY**

**14 MEDICATIONS, DRUGS, VITAMINS, SUPPLEMENTS**  
(past & present)

**15 RECREATIONAL or OCCUPATIONAL FACTORS**  
(e.g., sports, computer work, heavy lifting, etc.)

**16 SECONDARY COMPLAINTS**

**17 X-RAY REPORT**  
(narrative)

**17 IMPRESSION**  
(summary of x-ray report)

# PHYSICAL EXAMINATION

PATIENT NAME: \_\_\_\_\_

## SUMMARY OF FINDINGS

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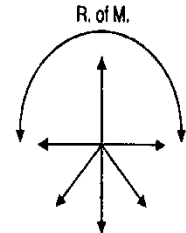
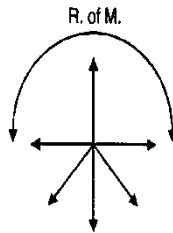
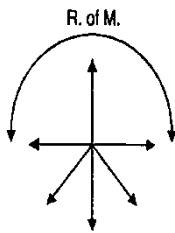
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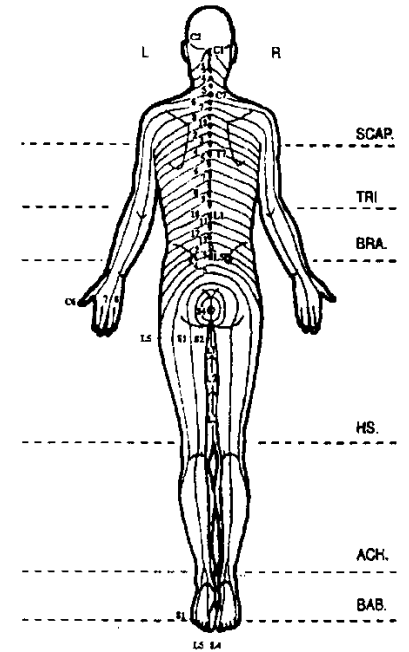
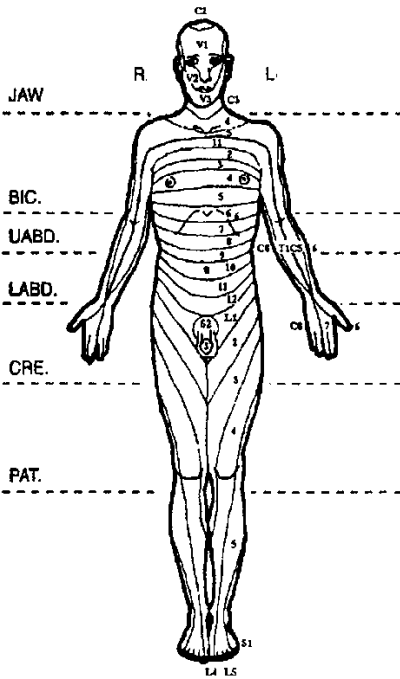
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LEFT	SEGMENT	RIGHT
	Occ	
	C1	
	C2	
	C3	
	C4	
	C5	
	C6	
	C7	
	T1	
	T2	
	T3	
	T4	
	T5	
	T6	
	T7	
	T8	
	T9	
	T10	
	T11	
	T12	
	L1	
	L2	
	L3	
	L4	
	L5	
	S/1	



### DIAGNOSIS & PHYSICAL IMPRESSION:

Narrative diagnosis preferred.  
ICD-9 codes = insufficient.

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**TREATMENT PLAN:** modality of care, frequency and duration of care, and re-evaluation interval. (Modality e.g., SMT, ART, Graston, laser, ultrasound, electrical stimulation, controlled exercise plan, lifestyle counseling, etc.)

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# Payment Contract

Dated: \_\_\_\_\_

Alberta Health Care Insurance Plan has been delisted effective July 1, 2009.

I understand that I am responsible to pay **\$95 for the initial visit, and \$59 per subsequent visit(s)**. Seniors and children pay **\$47 per subsequent visit(s)**. **Extended follow-up visits are \$89.**

I clearly understand and agree that **all charges that are not covered by my insurance company are charged directly to me and that I am personally responsible for payment.**

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

\_\_\_\_\_  
Signature (or Legal Guardian)

\_\_\_\_\_  
Absolute Health Incorporated Witness Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Absolute Health Incorporated Representative

# Cancellation & Missed Appointment Policy

Dated: \_\_\_\_\_

I clearly understand and agree that missed appointments, or appointment changes made less than six (6) business hours prior, are charged a **\$25 missed appointment fee**.

If I am unable to make my scheduled appointment, I will advise Absolute Health Incorporated **at least six (6) business hours before my scheduled appointment** by calling their office at (780) 448-5888, and I will leave a message if I get through to the answering machine.

I understand that Absolute Health Incorporated is sensitive to extenuating circumstances which arise and will be considerate of such when enforcing this policy. I agree to discuss any such circumstances at the soonest opportunity with the staff or practitioners at Absolute Health Incorporated, as soon as I possibly can.

\_\_\_\_\_  
Signature (or Legal Guardian)

\_\_\_\_\_  
Absolute Health Incorporated Witness Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Absolute Health Incorporated Representative

# CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

## Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

## Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

**Alternatives**

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

**Questions or Concerns**

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

**Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.**

**DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR**

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

\_\_\_\_\_ Date: \_\_\_\_\_ 20\_\_\_\_.  
Name (Please Print)

\_\_\_\_\_ Date: \_\_\_\_\_ 20\_\_\_\_.  
Signature of patient (or legal guardian)

\_\_\_\_\_ Date: \_\_\_\_\_ 20\_\_\_\_.  
Signature of Chiropractor



# SOAP/Progress Notes

Patient name: \_\_\_\_\_

Date	OC	T1	T7	L1		
	C1	T2	T8	L2		
	C2	T3	T9	L3		
	Q	C3	T4	T10	L4	
		C4	T5	T11	L5	
		C5	T6	T12	SI	
	X-ray	C6			Sac	
C7						

Date	OC	T1	T7	L1		
	C1	T2	T8	L2		
	C2	T3	T9	L3		
	Q	C3	T4	T10	L4	
		C4	T5	T11	L5	
		C5	T6	T12	SI	
	X-ray	C6			Sac	
C7						

Date	OC	T1	T7	L1		
	C1	T2	T8	L2		
	C2	T3	T9	L3		
	Q	C3	T4	T10	L4	
		C4	T5	T11	L5	
		C5	T6	T12	SI	
	X-ray	C6			Sac	
C7						

Date	OC	T1	T7	L1		
	C1	T2	T8	L2		
	C2	T3	T9	L3		
	Q	C3	T4	T10	L4	
		C4	T5	T11	L5	
		C5	T6	T12	SI	
	X-ray	C6			Sac	
C7						

Date	OC	T1	T7	L1		
	C1	T2	T8	L2		
	C2	T3	T9	L3		
	Q	C3	T4	T10	L4	
		C4	T5	T11	L5	
		C5	T6	T12	SI	
	X-ray	C6			Sac	
C7						

Date	OC	T1	T7	L1		
	C1	T2	T8	L2		
	C2	T3	T9	L3		
	Q	C3	T4	T10	L4	
		C4	T5	T11	L5	
		C5	T6	T12	SI	
	X-ray	C6			Sac	
C7						

